

EVENT PARTICIPATION FORM

Event Name: _____ Departure (Date/Time): _____ Departure (Date/Time): _____

Chaperone(s): _____ Event City/Address: _____

Student Name: _____ Date of Birth: _____ Age: _____

Student Address: _____

Student Cell Phone #: _____ Emergency Contact Phone #: _____

Mother: _____

Father: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Emergency Treatment Authorization

In case of an emergency, the chaperone listed above shall make every reasonable effort to contact parent(s) at the telephone numbers listed above. If the contact cannot be made with the parent(s), the chaperone is hereby authorized to contact medical personnel on behalf of the student to provide for emergency care. Emergency personnel are authorized to provide all services necessary to diagnose and treat the emergency condition. Such services shall include the administration of all appropriate medications. To facilitate billing for such services, please provide the name of your health and/or dental insurance carrier and the policy number associated with that policy:

Health Insurance Carrier: _____ Policy #: _____

Dental Insurance Carrier: _____ Policy #: _____

Please list the name and dosage of any MEDICATION that your child is currently taking: _____

Please list the name of ALLERGIES: _____

PARENT SIGNATURE: _____ **DATE:** _____